



**MARYLAND**  
Department of Health

**Maryland AIDS Drug Assistance Program**  
500 N. Calvert St., 5th Fl., Baltimore, MD 21202  
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308  
or TTY- Maryland Relay Service 1-800-735-2258  
Fax Numbers: (410) 333-2608; (410) 244-8696; (410) 244-8617  
Website: <http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx>

## A-1: MADAP Medical Eligibility Form

**Instructions:** This form must be completed by the licensed medical practitioner who provides the applicant's HIV-related care. Once all sections have been completed, signed and dated, it may be submitted to MADAP with the rest of the application or faxed to MADAP by the provider.

### Applicant's Information:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

☐ Check here if you do not have a social security number.

### 1. Viral Status:

Is this patient HIV infected?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If No, stop here, this patient is ineligible for MADAP)
Has this patient's case been reported by you to the local health department as required by state law?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this patient have a CD4+ T-lymphocyte test result that was <200 cells/μL (14%)? <i>If this patient is &lt;1 yr. of age, evidence of CD4+ test result &lt;750 cells/μL (&lt;26%)?</i> <i>If this patient is 1-5 yrs. of age, evidence of CD4+ test result &lt;500 cells/μL (&lt;22%)?</i>	<input type="checkbox"/> Yes Date ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has this patient been diagnosed with any Stage-3-defining opportunistic illness by CDC case definition* for HIV Infection?	<input type="checkbox"/> Yes Date ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Does this patient have a history of Hepatitis C virus (HCV) infection?	<input type="checkbox"/> Yes, with detectable HCV RNA <input type="checkbox"/> No, HCV ab negative/undetectable HCV RNA <input type="checkbox"/> Yes, with undetectable HCV RNA from treatment <input type="checkbox"/> No HCV test on record

\*Revised Surveillance Case Definition for HIV Infection – United States, 2014: MMWR 2014;63(No RR-03):1-10 Website: [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr)

### 2. Medication: Applicant must be on HIV antiretroviral medications or have ARVs prescribed within 3 months of submitting this application to be eligible for MADAP.

Are you currently prescribing at least one of the HIV antiretroviral medications on the Maryland AIDS Drug Assistance Program (MADAP) formulary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, are you planning to prescribe at least one of the HIV antiretroviral medications on the MADAP formulary in the next 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 3. Laboratory Reports:

Enter this patient's most recent CD4 Count and Viral Load test results. <i>If the patient's CD4 count is &gt;500 cells/μL and Viral Load is &lt; 200 copies/mL, the CD4 test date may be older than 12 months.</i> <b><u>VIRAL LOAD test date must be within the last 12 months.</u></b>		<b>Test Date</b>	<b>Test Result</b>
	<b>CD4 Count</b>	mm dd yyyy / /	cells/μL
	<b>Viral Load</b>	mm dd yyyy / /	copies/μL

### 4. HIV Exposure Category: Check one

<input type="checkbox"/> Male who has sex with males (MSM)	<input type="checkbox"/> Heterosexual contact	<input type="checkbox"/> Not Reported
<input type="checkbox"/> Injection drug use (IDU)	<input type="checkbox"/> Receipt of blood transfusion, blood components, or tissue	<input type="checkbox"/> Other:
<input type="checkbox"/> Hemophilia/coagulation disorder	<input type="checkbox"/> Mother with or at risk for HIV infection (perinatal transmission)	

### 5. Medical Practitioner's Information (Physician, Nurse Practitioner or Physician Assistant):

Name:	Degree:	Phone #:	Fax #:
Street Address:		License Number & Issuing State:	NPI#:
City:	State:	Zip Code:	Signature: _____ Date: _____